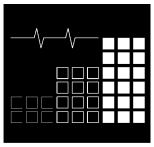

WASHINGTON
HEALTH CARE FACILITIES
AUTHORITY

APPLICATION FOR FINANCIAL ASSISTANCE – EZ QUIP

1. LEGAL NAME OF ENTITY:

2. DESCRIPTION OF ENTITY: (e.g., hospital, system, community health center, etc.)

3. ADDRESS:

   TELEPHONE: FAX:

4. PLEASE INDICATE THE APPLICANT'S CURRENT DEBT RATING (IF ANY) AND THE RATING AGENCY:

   Rating(s):

   Agency(ies):

5. PRINCIPAL CONTACTS: (including counsel)

   Name: Title:

   Phone: Fax:

   Name: Title:

   Phone: Fax:

6. SUMMARY PROJECT OR EQUIPMENT DESCRIPTION (Also attach itemized equipment list with item of equipment, make, model number, description, serial number, location (department and street address), and any other project cost (e.g., related renovations, installation or development cost and project use of equipment):

7. TOTAL AMOUNT OF LEASE FINANCING REQUEST: $
   Equity Contribution: $
   Other Sources of Funds: $
   TOTAL PROJECT COSTS: $

   Anticipated or Maximum Interest Rate: Term:

8. EXPLAIN OTHER SOURCES OF PROJECT FINANCING:

9. DETAILS OF REQUEST:

Type of Project		**Total Cost**	**Amount to be Financed with Lease**	**Reasonable Expected Economic Life**	**Preferred Length of Loan***
Property Acquisition	$		$	yrs.	yrs.
Construction	$		$	yrs.	yrs.
Renovations	$		$	yrs.	yrs.
Equipment	$		$	yrs.	yrs.
Refinancing	$		$	yrs.	yrs.

_____

**** Generally limited to economic life of asset financed.***

10. REIMBURSEMENT FOR PRIOR EXPENSES: $
Will construction be necessary to install equipment? YES NO
If yes, estimated cost: $
Completion Date:
Description of how prior expenses were financed:

11. ESTIMATED AMOUNTS AND DATES OF DRAWDOWNS OF LOAN PROCEEDS:

DATE	**AMOUNT OF DRAWDOWN**
	$
	$
	$
	$
	$
	$
	$
	$

Please attach expanded drawdown schedule, if necessary.

12. UTILIZATION:

Complete the chart below for the last five years.

	20	20	20	20	20	**Current YTD** 20
Licensed beds						
Operated beds						
Admissions						
Patient Days						
Average length of stay						
Occupancy*						

Emergency Visits						
Outpatient Visits						
Outpatient surgery visits						

** Based on beds.*

Discuss these utilization trends and reasons for variations.

13. OTHER SERVICE AREA HOSPITALS:

Hospital	No. of Beds	Occupancy	Estimated Distance

List cities and towns making up the primary service area and describe briefly your competitive position in the service area, specifying your market share in both primary and secondary markets. Please note services provided principally or exclusively by your hospital as compared with others.

14. REVENUE COMPOSITION:

Outline as indicated below the source of hospital revenues for the last five years.

	20	20	20	20	20
Medicare					
Medicaid					
Blue Cross					
Commercial Insurance					
Self-pay					
Other					
HMOs					

15. DISCUSS FINANCIAL TRENDS AND REASONS FOR VARIATIONS:

16. DOCUMENTS TO BE SUBMITTED TO BOND COUNSEL:

i. Entity's meeting minutes approving this loan application and/or reimbursement of prior expenditures;
ii. Letters from attorneys or auditors regarding pending or current litigation;
iii. Copy of facility license;
iv. Articles of Incorporation and By-Laws;
v. State tax exemption letter;
vi. Internal Revenue Service exemption letter;
vii. Current contracts, leases, guarantees or other commitments of more than one year duration;
viii. Latest IRS Form 990.

17. INFORMATION TO BE SUBMITTED WITH APPLICATION:

i. Photocopies of audited financial statements for the past five years, with auditors' management letters.
ii. Most recent year-to-date unaudited financial statements, including balance sheet and statement of revenues, expenditures, and transfers.
iii. Current fiscal year budget and operations to date versus budget, and projected budgets, if available.
iv. Legal documents for any existing debt.
v. Any available brochures or catalogs describing the institution or its programs.

18. CERTIFICATION

I, the undersigned, request that this application be submitted for review. I hereby certify that the information contained herein and the attachments hereto are to the best of my knowledge and belief accurate and descriptive of the project which is intended as security for the requested financing. I authorize the Washington Health Care Facilities Authority to undertake the preparation of tax-exempt lease financing documentation and any notices, hearings or other actions taken by the Authority to facilitate the financing requested hereby, and agree to reimburse the Authority for out-of-pocket expenses incurred in connection with taking such actions, including, but not limited to, bond counsel fees, costs of advertising public notices, financial advisor's fees, and other disbursements related to preparing the proposed financing. I understand that the Authority makes no commitment to provide financing and that such financing is conditional upon the approval of the Authority and the execution of legally binding commitments acceptable to all parties.

Applicant Name

Applicant Signature _____

Title

Date

19. HARD COPY SUBMISSION:

Please mail seven (7) copies of the completed application along with the $7,500 application fee to:

Washington Health Care Facilities Authority
Attention: Donna Murr
410 11th Avenue SE, Suite 201
Olympia, WA 98504-0935

ELECTRONIC SUBMISSION:

For electronic submission, please e-mail the application to donnam@whcfa.wa.gov and mail one (1) signed original with all attachments along with the $7,500 application fee to the address listed above.